Trauma Therapist Florida

Laura Durant, LMHC, Inc.

Policy and Procedures

Consent for Treatment, Authorization for Payment, Cancellation Policy

I hereby voluntarily apply for and consent to mental health evaluation and/or treatment by Laura Durrant, LMHC, Inc., for my minor child or myself.

Initial _____ I understand that it is my responsibility to cooperate with evaluation and/or/ treatment to the best of my ability, with full knowledge of the benefits and consequences of psychotherapy. I understand Florida State, Federal law and professional ethical standards provide for the confidentiality of psychiatrist/ psychotherapist/client communications including records. {Your provider and this office will not disclose or confirm your use of serves at this office. Lawful and legally required exceptions to this privilege of confidentiality include; information of child abuse, elder abuse, the immediate physical danger to yourself or another, a lawful court order and your signed consent.

Initial_____ A copy of the HIPAA Notice of Privacy Practices has been made available to me.

Initial_____ Fee schedule: Initial Evaluation: $300.00: Individual Psychotherapy session 200.00 per hour.

Initial_____ Because time has been reserved for me and/or members of my family. I understand that, except in a true emergency, I am expected to provide at least 24 hours advanced notice if I am unable to keep a previously scheduled appointment. For your information, date and time stamped voicemail is available 24/7 and does suffice for giving adequate notice. **In the event that I do not provide notice at least 24 hours prior to canceling an appointment I understand that I will be charged $200.00 appointment no show' fee.**

Initial _____ I understand that time spent on my behalf, or for my child, that involves telephone calls, preparation of letters or reports, attendance at schools, depositions, legal proceedings, or other conferences are my financial responsibility and I will be responsible at the prevailing hourly rate for those services. Also, should this account be sent to an outside agency for collection of a balance due, I am aware that I will be responsible for all and any fees assessed.

My signature below indicates that I have read and agree to all policies.

Signature: _____ Date: _____

Witness Signature:_____ Date: _____